

NREPP National Registry of Evidence-based Programs and Practices

## The New NREPP: Advancing Evidence-based Practice through Improved Decision Support Tools

COCE-CAPT Conference Call  
March 20, 2006

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## SAMHSA Vision for NREPP

“NREPP becomes a leading national resource for contemporary and reliable information on the scientific basis and practicality of interventions to prevent and/or treat mental illness and substance use and abuse.”

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## NREPP represents:

- A major agency activity within SAMHSA's Science to Service initiative
- A decision support system that will facilitate evidence-based decisionmaking and practice
- A valuable resource for state and community-based organizations seeking to identify and select programs and practices

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## Brief History

1998: Began as **National Registry of Effective Prevention Programs** through SAMHSA's Center for Substance Abuse Prevention

1998-2003: Reviewed and rated over 1,100 substance abuse prevention programs, information on over 150 Model, Effective, and Promising Programs on Web site ([www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov))

2004: Initial expansion of system to include substance abuse treatment, and mental health promotion and treatment programs

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## Recent Developments / Current Status

- NREPP contract transitioned to MANILA Consulting Group in Fall 2004
- Federal Register Notice (FRN) and public comment period initiated in August 2005
- Announcement of new NREPP decision support system and review procedures: March 14, 2006
- New NREPP reviews and re-reviews initiated by Summer 2006;
- NREPP Web site launch in Fall 2006 – [www.nationalregistry.samsha.gov](http://www.nationalregistry.samsha.gov)

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## Key Features of the New NREPP

- Including of more programs/practices
- Expanding what type of evidence is “acceptable”
- Setting review priorities
- Emphasis on outcomes
- Elimination of arbitrary labels

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## Overview of the New NREPP

- Streamlined Review Procedures
- Decision Support Tool Dimensions

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## Streamlined Review Procedures

Centers within SAMHSA annually establish review priorities regarding:

- Content areas (e.g., homelessness)
- Intervention approaches (e.g., community-based outreach)
- Populations (e.g., older adults)
- Research designs (e.g., quasi experiments and RCTs)
- Inclusion of behavioral and/or non-behavioral outcomes

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## Streamlined Review Procedures

Reviews are facilitated by doctoral-level Review Coordinators

- Review application materials for completeness
- Document and verify intervention approaches and outcomes achieved
- Work with applicants to expedite reviews
- Work with applicant to draft summary descriptive dimensions
- Work with 2 Reviewers who independently rate outcome-level evidence on two quantitative dimensions for each intervention

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## Streamlined Review Procedures

Re-reviews of current NREPP Model, Effective and Promising Programs

- Center Directors establish priorities
- Staged approach: Model programs followed by Effective and Promising
- Current listings on Model Programs site remain until posting to new NREPP web site
- New NREPP Web site launch in Fall 2006
- Goal is to include a balance of new and existing programs

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## Notifications to Program/Practice Developers

- Notified in writing within 2 weeks of the review results
- Review complete program summary, including descriptive and rating dimensions
- Opportunity to discuss any concerns with Review Coordinator and/or Program Manager at MANILA
- If disagreements not resolved in 2 weeks, then written appeals for a re-review of the intervention may be considered on a case-by-case basis

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## Decision Support Tool Dimensions

- Descriptive Dimensions
- Rating Dimensions
  - ✓ Strength of Evidence
  - ✓ Readiness for Dissemination

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## Descriptive Dimensions

- **Intervention Name and Summary**
- **Contact Information**
- **Outcomes Achieved-** Each outcome is assessed by Reviewers using Rating Dimensions
- **Effects and Impacts-** Statistical, practical and/or clinical significance of outcome findings

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## Descriptive Dimensions Continued

- **Relevant Populations and Settings-** Describes the populations and sample demographics that characterize existing evaluations. Evaluations settings are characterized as:
  - ✓ Efficacy studies
  - ✓ Effectiveness studies
  - ✓ Dissemination studies
- **Estimated Costs**

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## Descriptive Dimensions Continued

- **Evaluation Design**

Searchable index of specific experimental and quasi-experimental design types:

The pyramid diagram illustrates the hierarchy of evidence-based research designs. The levels, from top to bottom, are: Meta Analyses / Expert Panel Reviews of Research Evidence, Replicated RCTs or Quasi-Experimental Designs, Single Randomized Control Trial (RCT), Single Quasi-Experiments, Single Group Pre- to Post-test Designs, Pilot Studies, Case Studies, and Observation.

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## Descriptive Dimensions Continued

- **Replication(s)-** Describes the number of replications that have been conducted in efficacy, effectiveness, or dissemination contexts
- **Adverse Effects**
- **Cultural Appropriateness-** Describes whether intervention materials are specific to culturally-identified groups

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## Descriptive Dimensions Continued

- **Proprietary Materials**
- **Implementation History-** Describes the frequency, and duration of prior implementations; number of participants served.

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## Rating Dimensions: Strength of Evidence & Readiness for Dissemination

- **Criterion-based ratings from 2 independent Reviewers**
- **Score range is 0 to 4 for each criterion**
- **Average is provided for each overall dimension** (i.e., score is averaged across criteria and Reviewers)
- **Average is provided for each criterion** (i.e., score is averaged across Reviewers). Includes Reviewer narrative comments

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## Rating Dimensions

Reviewers independently rate each intervention outcome on these criteria:

- **Strength of Evidence**
  1. Reliability
  2. Validity
  3. Intervention Fidelity
  4. Missing Data and Attrition
  5. Potential Confounding Variables
  6. Appropriateness of Analyses

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## Rating Dimensions <sup>Continued</sup>

- **Readiness for Dissemination**
  1. Availability of Implementation Materials
  2. Availability of Training and Support Resources
  3. Quality Improvement Materials

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### Find A Program

Program Details

**This is a proposed mockup of a program summary using a fictitious program.**

**Program Details: Brief Integrated Behavioral-Psychodynamic Therapies (BIBPT) for Axis II Disorders (Fictitious Program)**

**Gold Standard:** January 24, 2006  
**Population:** Adults meeting the DSM-IV-TR diagnostic criteria for one or more Axis II disorders.  
**Setting:** Rural independent facilities in the Southern United States.  
**Intervention:** Program has been implemented in 4 rural independent treatment facilities in New Mexico and Arizona. Replications of the model are underway in other states (TX, CA).  
**History:**

**Program Summary**  
 BIBPT for Axis II Disorders is a fictitious, short-term integrated behavioral-psychodynamic treatment program designed to engage patients in brief outpatient treatment and reduce distress from DSM-IV Axis II disorders within 30 days. Patients participate in optional group counseling sessions for 4 weeks, then once weekly sessions as part of a 12-week comprehensive aftercare program.

**Contact Information**  
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**Outcomes**  
 • Improved Interpersonal Functioning

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 • Improved Interpersonal Functioning  
 • Treatment Retention

**Additional Program Information**

**Estimated Costs**

Component / Resource	Estimated Implementation Costs	Estimated Maintenance Costs
BIBPT Training Course	\$15,000	\$750
Group Therapy Facilitator (salary)	\$26,000	\$26,000

**Population- and Culture-specific Adaptations**  
 Adaptations for specific groups are not available.

**Proprietary Components**  
 There are no proprietary components of this intervention. All materials are in the public domain.

**Adverse Effects**  
 No adverse or unintended effects from this intervention have been reported.

**Review Funded by:**  
 by Center for Mental Health Services (CMHS)

**Improved Interpersonal Functioning**  
 Defined as within- and post-treatment self-reports of decreased problematic social interactions.

**Research Design:** Randomized Controlled Trial

**Effects and Impact:** Statistically significant between group effects ( $p < .05$ ).

**Replications:** (Scale Range = 0 to 4)  
 • Strength of Evidence: 3.7  
 • Readiness for Dissemination: 2.3

**Replications:** 5 studies

A PDF is available with complete findings for this outcome.

**Improved Interpersonal Functioning**  
 Defined as within- and post-treatment self-reports of decreased problematic social interactions.

**Research Design:** Randomized Controlled Trial

**Effects and Impact:** Statistically significant between group effects ( $p < .05$ ).

**Replications:** (Scale Range = 0 to 4)  
 • Strength of Evidence: 3.7  
 • Readiness for Dissemination: 2.3

**Replications:** 5 studies

A PDF is available with complete findings for this outcome.

**Treatment Retention**  
 Defined as a client's attending at least three (3) weekly sessions in the 30 days following intake.

**Research Design:** Randomized Controlled Trial

**Effects and Impact:** Statistically significant between group effects ( $p < .05$ ).

**Replications:** (Scale Range = 0 to 4)  
 • Strength of Evidence: 3.7  
 • Readiness for Dissemination: 2.3

**Replications:** 5 studies

A PDF is available with complete findings for this outcome.

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